Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY CENTER OF COLUMBIA
725 S. JAMES CAMPBELL BLVD
COLUMBIA TN 38401

Respondent Name

COMMERCE & INDUSTRY INSURANCE

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2672-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "no payment made. paid on previous visit for same procedure . *see attached paid EOB."

Amount in Dispute: $1,725.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2010	ASC Services for Code 62311	$1,725.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a complete medical bill.
4. 28 Texas Administrative Code §133.10, effective May 1, 2008, sets out the requirements for a complete medical bill.

5. 28 Texas Administrative Code §133.20, effective January 29, 2009, requires a health care provider to include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 12, 2010
   - 18-Duplicate claim/service.
   - *-This bill was received electronically from the provider (no paper bill received). (Z160)

   Explanation of benefits dated December 7, 2010
   - (220)-the applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required.
   - This procedure code is invalid on this date of service according to the Texas Fee Schedule. Resubmit the entire bill with a valid code for this charge. (B256)
   - Previously requested information/documentation has not been received. (X022)
   - Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution. (X394)
   - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor bill the disputed service in accordance with 28 Texas Administrative Code §133.10?

Findings

1. The requestor provided services in the state of Tennessee on August 23, 2010, to an injured employee with an existing Texas Workers' Compensation claim. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor was not satisfied with the respondent's final action. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The respondent denied reimbursement for the disputed ASC services based upon billing of an invalid code. A review of the submitted medical bill and EOBs indicate that the code billed was "0490".

   28 Texas Administrative Code §133.2(2) states "Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing)."

   28 Texas Administrative Code §133.10(f)(1), sates "The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (Q) requires procedure/modifier code (CMS-1500, field 24D) is required."

   28 Texas Administrative Code §133.20 (c) requires "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

   A review of the submitted medical bill does not list CPT codes required by 28 Texas Administrative Code §133.10(f)(1) and §133.20 (c) for billing ASC services.

   The Division concludes that the requestor did not bill for the disputed services with a CPT code required by 28 Texas Administrative Code §133.20 (c). Furthermore, the requestor did not support position that the service listed on the Table of Disputed Services, CPT code 62311, was ever submitted to the respondent prior to seeking medical fee dispute resolution. For these reasons, reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under

Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		2/21/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.